Department of Industrial Relations, Industrial Medical Council P. O. Box 8888, San Francisco, CA 94128 (800) 794-6900

State of California

TREATING PHYSICIAN'S DETERMINATION OF MEDICAL ISSUES

(The use of this form is optional. You may use it for interim/supplemental reports, at the completion of treatment, patient's discharge or when patient becomes permanent and stationary to address relevant issues. Read the affirmation and sign page 2. Attach additional pages if necessary.)

Employee: _____ 2. Claim Number: _____
1. (Last Name) (First Name) (M.I.)

3. Social Security Number: ___ – ___ – ___ (For record keeping purposes only) 4. Date of Birth: ___/___/___ mm/dd/yy 5. Date of Injury(ies): ___/___/___ mm/dd/yy

6. Occupation Title: _____ 7. Date of This Exam ___/___/___ mm/dd/yy 8. Date of Next Exam ___/___/___ mm/dd/yy

9. **Employer:** _____ 10. **Insurer/Claims Administrator:** _____

Consult Necessary? Yes ☐ No ☐ Referral Necessary? Yes ☐ No ☐ Primary Treating Physician (name): _____

11. **Current Diagnosis** **Use ICD-9 Codes or DSM-IV (Also state diagnosis in lay terms if possible)**

Primary: _____

Other: _____

PATIENT STATUS

12. **Since the last exam, the patient's condition has: (Check applicable boxes)**

☐ improved as expected ☐ improved, but more slowly than expected ☐ not improved significantly ☐ worsened

☐ now been determined to be non-work related ☐ plateaued, no further improvement is expected ☐ Check only if patient has been discharged from care on ___/___/___ mm/dd/yy

13. Patient has been complying with treatment regimen. ☐ YES ☐ NO

14. **Objective or Clinical Findings.**
Give all significant physical or psychological examination, testing, laboratory, imaging or diagnostic findings including applicable measurements. (Use glossary of activity terms as applicable)

15. **Subjective Findings.**
Describe the complaints in the patient's own words. Then, using the standard terminology (listed in instructions under terms that describe intensity of pain) separately describe the subjective findings and list any aggravating or mitigating factors. Also, list relevant prior injuries/impairments/disabilities.

16. **History of Injury/Changes in condition**

WORK STATUS

17. **The patient has been instructed to:**

☐ remain off the rest of this day and return to work Estimated date patient can return to work ___/___/___ mm/dd/yy
- ☐ with no limitations
- ☐ with limitations of _____

☐ now return to work Date returning to work ___/___/___ mm/dd/yy
- ☐ with no limitations
- ☐ with limitations of _____

☐ remain off work and continue treatment Estimated date patient can return to work ___/___/___ mm/dd/yy

TREATMENT

18. **Treatment Plan (complete all that apply)**

- ☐ has not changed from last report
- estimated date of completion of treatment ___/___/___ mm/dd/yy
- ☐ current Medication: _____
- ☐ current Physical Medicine/Therapy. Type: _____
  - Frequency: _____
  - Duration: _____

Attach and briefly describe any new reports for:

- ☐ Diagnostic Studies: _____
- ☐ Hospitalization/Surgery: _____
- ☐ Consultation/Other Services: _____

19. **Comments:** (Note any changes in treatment plan)

PERMANENT DISABILITY STATUS

20. **Patient is: (Check applicable boxes)**

- ☐ discharged, pre-injury status achieved (Do not prepare narrative report unless requested).
- ☐ permanent & stationary (maximum medical improvement) (see box at bottom of this page).
- ☐ permanently precluded from engaging in his/her usual and customary occupation (attach RU-90).
- ☐ I am unable to determine patient's permanent disability status at this time.

AFFIRMATIONS

I personally prepared this report. Any parties assisting in the records review, evaluation or testing procedures are listed in the attachment to this report.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted in this report, that I believe it to be true. I have not violated Labor Code Section 139.3, and the contents of this report and bill are true and correct to the best of my knowledge.

The foregoing declaration was signed in _____ County, California, on ___/___/___ mm/dd/yy

Signature _____ License No _____

Name (typed or printed) _____ Specialty (if any) _____
LAST FIRST M.I.

Address: _____ _____ _____ (___) _____
(Street or P. O. Box) City Zip Telephone Number

Note to physician. If this is a final report, you are required to serve this report on the claims administrator and patient/patient's attorney.

IF THIS IS A FINAL REPORT AND THE PATIENT HAS NOT ACHIEVED PRE-INJURY STATUS, THE FOLLOWING ISSUES, IF RELEVANT, SHOULD BE ADDRESSED IN NARRATIVE FORMAT. THIS REPORT WILL BE USED TO RATE YOUR PATIENT'S DISABILITY. YOUR OPINIONS CARRY GREAT WEIGHT. YOU MUST DESCRIBE THE BASIS FOR YOUR CONCLUSIONS IN YOUR REPORT. YOU MUST ALSO PROVIDE A LISTING OF ALL INFORMATION RECEIVED FROM THE PARTIES, REVIEWED IN PREPARATION OF THE REPORT OR RELIED UPON FOR THE FORMULATION OF YOUR OPINION. IF THE INJURY IS ALLEGED TO BE A PSYCHIATRIC INJURY, A DETERMINATION OF THE PERCENT OF THE TOTAL CAUSATION RESULTING FROM ACTUAL EVENTS OF EMPLOYMENT IS REQUIRED. SEE ATTACHED GLOSSARY OF ACTIVITY TERMS AND TERMS THAT DESCRIBE INTENSITY OF PAIN AND FREQUENCY OF SYMPTOMS.

ISSUES WHICH SHOULD BE ADDRESSED, IF RELEVANT, IN NARRATIVE REPORT

History of the Injury or Illness. Outline the specific details of the injury or illness. Describe the course(s) of treatment, diagnostic procedure performed and give names of any other treating or consulting physicians.

General Medical History. Describe any previous, current or subsequent medical information relevant to this injury or illness.

Occupational History. Description of present and prior occupational duties. List source of description of duties. Where possible, use RU91, DEU 100's job Analysis or you may use the Occupational History Form from the Physician's Guide.

Present Complaints. Describe in the patient's words and also report using the appropriate medical terminology.

Examination Findings. Use objective measurements where appropriate. Give all significant physical or psychological examination, testing, laboratory, imaging, or diagnostic findings.

Diagnostic Impression. Where possible, use ICD-9 codes or terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised.

Permanent Disability. Describe in appropriate terminology from the instructions your evaluation of the subjective and objective findings that describe both the intensity and frequency of the symptoms. Give measurements or objective factors if relevant. Describe any reduction of pre-injury work capacity, citing documentation or source of pre-injury capacity.

Work Limitations. Describe any limitations to all activities listed in the instructions.

Causation. Describe how the permanent disability is related to the patient's occupation and the specific injury or cumulative events causing this illness. You may refer to the Physician's Guide for discussions.

Apportionment. If any of the permanent disability arose or has arisen from other factors, (i.e. other injuries, underlying medical condition) describe the apportionment between the disability resulting from this injury and any previous or subsequent disability. You may refer to the Physician's Guide for discussions.

Medical Care. Describe any need for ongoing or future medical care as it relates to the industrial injury. Be as specific as possible regarding the type and frequency of care that will probably be needed in the future.

Vocational Rehabilitation. Is the patient able to continue doing the type of work in which he/she was engaged at the time of injury/ illness? If not, what specific modifications would be medically appropriate? What work restrictions or limitations are appropriate? (This should be consistent with work limitations above). Indicate what source you used to describe the duties of the patient's job at the time of injury. (This should be consistent with occupational listing above).

Psychiatric Protocols. If psychiatric disability exists, please refer to the psychiatric protocols established by the Industrial Medical Council. (8CCR § 43) (Copies are available at (800) 794-6900).

Affirmations. The affirmations on page 2 must be included in any additional final narrative report in which the patient has not achieved pre-injury status.

Except as prohibited by Labor Code section 139.3, a primary treating physician may designate another physician who is licensed in California to prepare the final report.

You need not file or serve this page or the instruction page with the Treating Physician's Determination of Medical Issues form. If you are not familiar with the terminology or reporting requirements for disability evaluations, you may refer to discussions in the "Physician's Guide" or the "Treating Physician's Alert" available from the IMC.

***** INSTRUCTIONS *****

GLOSSARY OF ACTIVITY TERMS

Balancing : Maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces, or maintaining body equilibrium when performing gymnastic feats.

Bending : Angulation from neutral-straight position about joint (e.g. elbow) or spine (forward or lateral spine flexion).

Carrying : Transporting an object, usually holding it in the hands or arms, or on the shoulder.

Climbing : Ascending or descending ladders, stairs, scaffolding, ramps, poles, and the like, using feet and legs and/or hands or arms. For climbing, the emphasis is placed upon body agility, for balancing, it is placed upon equilibrium.

Crawling : Moving about on hands and knees or hands and feet.

Crouching : Bending body downward and forward by bending legs and spine.

Feeling : Perceiving attributes of objects such as size, shape, temperature, or texture by means of receptors in skin particularly those of finger tips.

Fingering : Picking, pinching, or otherwise working with fingers primarily (rather than with whole hand or arm as in handling).

Handling : Seizing, holding, grasping, turning or otherwise working with hand or hands (fingering not involved).

Kneeling : Bending legs at knees to come to rest on knee or knees.

Lifting : Raising or lowering an object from one level to another (includes upward pulling).

Pushing : Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking, and treadle actions).

Pulling : Exerting force upon an object so that the object movers toward the force (includes jerking).

Reaching : Extending the arm(s) in any direction.

Sitting : Remaining in the normal seated position.

Standing : Remaining on one's feet in an upright position at a work station without moving about.

Stooping : Bending body downward and forward by bending spine and waist.

TERMS THAT DESCRIBE INTENSITY OF PAIN

A ***SEVERE*** pain would preclude the activity precipitating the pain.

A ***MODERATE*** pain could be tolerated, but would cause marked handicap in the performance of the activity precipitating the pain.

A ***SLIGHT*** pain could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.

A ***MINIMAL*** (mild) pain would constitute an annoyance, but would cause no handicap in the performance of the particular activity (and would be considered a nonratable permanent disability).

TERMS THAT DESCRIBE FREQUENCY OF OCCURENCE OF SYMPTOMS

Occasional means approximately 25% of the time.

Intermittent means approximately 50% of the time.

Frequent means approximately 75% of the time.

Constant means approximately 90-100% of the time.